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Current Issues in Breast Reconstruction

By Elena Prousskaia

Issue 1. Lack of Information for the Patients

Currently advantages of autologous reconstruction are getting more and more known by patients. Most women are now well informed and they then become the strongest advocates of the best treatment for themselves. Amazingly some of them are still not told that DIEP reconstruction can be an option or even worse they are informed that LD flap from the back which sacrifices functional muscle is as good as a DIEP flap from the abdomen which allows us to preserve muscle function.

Issue 2. Immediate Reconstruction Surprisingly Seems to Have Lower Satisfaction Rates

The decision whether to offer immediate or delayed reconstruction is usually guided by the potential need for radiotherapy and of how aggressive the cancer is. Immediate reconstruction offers cosmetically the best possible result but unfortunately many of these patients are less satisfied compared to women who have had to live without a breast before they get their reconstruction done. It is a paradox, but it makes me think sometimes that the most important outcome of breast reconstruction is a patient's satisfaction and somehow we miss this point giving them the best possible result but with lower satisfaction rate.

Issue 3. Disadvantages of Immediate-Delayed Reconstruction with Expander in Irradiated Field

In my breast reconstruction work I am seeing a large volume of patients who had so called immediate-delayed breast reconstruction where an expander was inserted immediately after mastectomy to provide the patient with certain volume while awaiting the final reconstruction. Patients are usually told that it is better than being flat. Unfortunately it is well known that if patient will have radiotherapy there is very high chance that she will end up with hard and painful lump instead of anything looking like breast because of developing capsular contracture in irradiated field. An expander in this case does not substitute the breast but creates pain, aesthetically unacceptable deformity and impossibility to fit the external prosthesis. The patient ends up lopsided and with difficulty of fitting in external prosthesis because of expander on her chest. These patients appreciate final outcome of reconstruction with their own tissue more than anybody else after living for a while with encapsulated expander. From an aesthetic point of view, in these cases I am rebuilding the breast using partially expanded skin which does not provide the volume of the other side. The best outcome of their reconstruction still looks worse than the result when the breast is rebuilt as a single unit from the flat chest. (See the Figure 1). In my opinion insertion expander as temporary reconstruction in patients who will have radiotherapy provides more disadvantages when advantages. Even if it is "convenient" to be able to tell the patient "you will not wake up completely flat" we should think about what it will bring to this woman for next year or two until she will be having final reconstruction.

Issue 4. When Breast Fat Grafting Is Indicated?

Lipofilling is a relatively new technique, which is becoming increasingly popular. It is well known that fat graft loses about 40-50% of its volume in a first 6 - 12 months after the surgery. It is also well known that only certain volume of it can be transplanted in a single procedure otherwise it will not be vascularized and will not survive. There are publications from mostly the same few authors in the world claiming that the breast can be completely rebuilt with fat grafting. In my experience some of these patients came to my clinic after having multiple general anesthetics for repetitive fat graft procedures and the result was not even close to looking like a breast. Considering lack of strong evidence in the literature I currently do not recommend to my patients fat graft as a technique to rebuild the entire